Virginia Commonwealth University

Accident Report of Workers' Compensation Claim

Complete *all* sections *within* 24 hours of injury or illness *before* claim can be filed.

To be eligible for benefits under the Workers' Compensation Act, VCU Employee Health Services *must* receive *both* this *completed* claim form (P-100) and the Physician Selection Form (P-101) by hand delivery or by mail:

- *Deliver to:* VCU Employee Health Services 1200 East Broad Street, West Hospital, West Wing, First Floor, Room 120
- *Mail to:* VCU Employee Health Services, P. O. Box 980134, Richmond, VA 23298-0134

EMPLOYEE SECTION – Complete, sign and give to supervisor.

Name: Small Marlene (last, first, middle) DOB: 7-9-69 ☐M ☒F ☐S ☐M ☐W ☐D (Marital Status)

ID#: _____ VCU Hire Date: _____ Home Address: 4123 Robert E. Lee Dr. (street, city, zip code)

Home Phone: (804) 458-5222 Department: Parking & Transportation Dept P.O. Box #: _____

Work Phone: (804) 827-0537 (Cell) (804) 640-2813 ☐Faculty/Staff ☒Hourly (Employee Type) ☐Other Hrs Worked: Daily 3 Weekly 33

Job Title: Parking Safety & Enforcement Location Where Injury Occurred: 13th St Parking Deck 3-Deck 1 (e.g., Sanger Hall R. 1-032)

Date of Injury: Oct 1, 2006 Time of Injury: 17:56 AM (PM) Day of Week: Sunday

Describe activity prior to accident *and* type of accident: *(Attach additional sheet if necessary.)*

Cause *and* object of injury *(Describe in detail how and why injury occurred. If by needle stick, give patient's name and chart #.)*

Injuries Sustained _____

Have you filed a WC claim(s) in the past? ☐Yes ☐No If "yes," list date(s): _____

Name(s) of any witness(es) _____

I certify that the information provided above is true and complete *(May be signed by person acting on employee's behalf.)*

Signature: _____ Date: _____

SUPERVISOR SECTION – Complete, sign and send to EHS. If you do not agree with the employee's report, please contact the VCU WC Off at 828-1633. For assistance in accident investigation/prevention, please contact the VCU Occupational Safety Office at 828-0040.

Was the employee doing something other than required duties at the time of the accident? ☐Yes ☐No If "yes," please explain

When did you first learn of this accident? Immediately after the accident occurred.

Was the employee given medical treatment? ☒Yes ☐No If "yes," physician's name and address: Patient First in Chester 12101 South Chalkley phone: 796-3

Was the place of the accident on VCU premises? ☒Yes ☐No If "no," please explain

Based on your investigation, what was (were) the cause(s) of the accident? *(Give details and attach additional sheet if necessary.)* please see attached sheet

How could this accident have been prevented? *(e.g., wear protective equipment, equipment should have been repaired, procedure changed, etc.)* The accident occurred during normal job functions and could not have been pr

What steps were taken to prevent another accident? *(e.g., Housekeeping contacted, training provided, etc.)* Air compressor was placed in a more easily accessible place.

Supervisor's Name: Katherine Mattley (please print) P.O. Box #: 843002 Work Phone: 827-

Signature: Katherine Mattley Date: 10/01/06

MEDICAL PERSONNEL SECTION – Complete, sign and forward to WC Office.

Date Seen: 10-2-06 Time Seen: 11:45 (AM) PM By Whom? Kim Clements, MD

Facility Address: 12101 S. Chalkley Rd Chester VA 23831

Diagnosis: Contusion - Scalp/Face Final

Was the diagnosis related causally to the accident? ☒Yes ☐No If "yes," please explain: Ms. Small hit her on concrete post

Lost Time? ☒Yes ☐No If "yes" – dates: 10-2-06 Probable Length of Disability: _____

Return to Duty? ☒Yes ☐No If "yes" – dates: 10-3-06 Regular Duty ☐ Light Duty ☐

Explain Duty Restrictions: Work/protect left side of face

Referral? ☐Yes ☒No If "yes" – where: _____ Who: _____

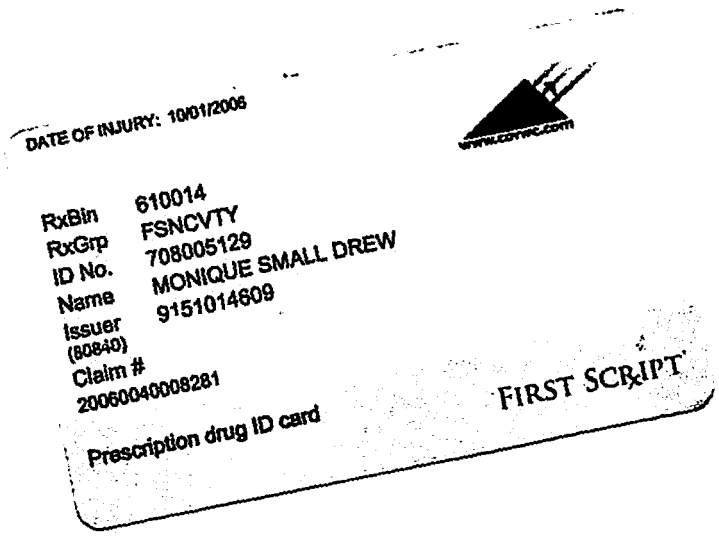
Follow-up? ☒Yes ☐No If "yes" – where: PT First When: 10-5-06

Completed by: Kim Clements, MD Date: 10-2-06 OSHA Case #: _____

VCU Human Resource Division FORM P-100 I

Kim C. Clement

10/12/06 ok


DATE OF INJURY: 10/01/2006
WWW.COVWC.COM
RxBin 610014
RxGrp FSNCVTY
ID No. 708005129
Name MONIQUE SMALL DREW
Issuer (80840) 9151014609
Claim # 20060040008281
Prescription drug ID card
FIRST SCRIPT